MEDICARE WITH MATT

The Plain-English Medicare Guide

Six modules. Two paths. Zero jargon.
Everything you need to make the Medicare decision once, and make it right.

Matt Villemure, Licensed Medicare Advisor
NPN 19346921 · Licensed in 21 states
(810) 775-6885 · medicareadvisormatt.com
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MODULE 1

Overview of Medicare

What Medicare is, who qualifies, and how the four parts fit together. Ten minutes here saves hours of confusion later, and the decision at the end of this path is one you only want to make once.

> **What you'll walk away with:** by the end of these six short modules you'll know which path fits your situation, what it should cost, and exactly when you need to act. And if you'd rather have all of it done for you, that's what Matt does every day, at no cost to you.

What Is Medicare?

Medicare is the federal health insurance program primarily for people 65 or older, though it also covers certain younger people with disabilities and those with End-Stage Renal Disease (ESRD).

It was signed into law in 1965 and today covers more than 65 million Americans. Understanding how it works is one of the most important financial decisions you'll make as you approach retirement.

> Medicare is NOT free. Most people pay premiums, deductibles, and copays. Understanding the costs is just as important as understanding the coverage.

The Four Parts of Medicare

Medicare is divided into four parts, each covering different services:

- **Part A (Hospital Insurance):** Covers inpatient hospital stays, skilled nursing facility care, hospice, and some home health care. Most people don't pay a monthly premium for Part A if they've worked and paid Medicare taxes for at least 10 years.
- **Part B (Medical Insurance):** Covers doctor visits, outpatient care, preventive services, and medical equipment. The standard premium in 2026 is $202.90/month, though higher earners pay more (IRMAA).

- **Part C (Medicare Advantage):** An alternative way to get your Medicare benefits through a private insurance company. We cover this in detail in Module 2.
- **Part D (Prescription Drug Coverage):** Helps cover the cost of prescription drugs. Covered in detail in Module 4.

Original Medicare vs. Medicare Advantage

One of the first decisions you'll face is whether to stay on **Original Medicare** (Parts A and B, plus an optional Part D and Medigap supplement) or enroll in a **Medicare Advantage** plan (Part C).

This is the single most important decision in your Medicare journey, and it's one that many people make without fully understanding the tradeoffs. We'll break both down in the following modules.

> **FROM MATT'S DESK**
>
> When **Frank D.** came to me, he was three weeks from turning 65 with a kitchen table buried in plan mailers, 40+ pieces of mail, six agents calling, and no idea that "Medicare Advantage" and "Medicare Supplement" were completely different things. We sorted his entire situation in one 20-minute call. He told me afterward the worst part wasn't the decision. It was the six months he spent dreading it.
>
> Client stories reflect real situations from Matt's practice. Names and identifying details are changed for privacy.

> **Not sure which path fits you?** That's the exact question Matt answers every day. A quick call now beats a year locked into the wrong plan, and it costs you nothing.

Who Qualifies?

- Age 65 or older (U.S. citizen or permanent legal resident for at least 5 consecutive years)
- Under 65 with certain disabilities after receiving Social Security disability benefits for 24 months
- Any age with End-Stage Renal Disease (ESRD) or ALS

When Does Coverage Begin?

Your Initial Enrollment Period (IEP) begins 3 months before your 65th birthday month and ends 3 months after. We go deep on all enrollment periods in Module 5.

Missing your enrollment window can result in permanent late enrollment penalties on your monthly premiums. Don't wait, understand your dates now.

Got a Question Already?

You don't need to finish the guide to ask. Matt answers quick questions by phone and text all day, and a 15-minute call now can save you a year on the wrong plan.

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MODULE 2

Medicare Advantage

How Advantage plans really work, including what the $0 premium ads don't tell you. Read this before you enroll in anything.

What Is Medicare Advantage?

Medicare Advantage (Part C) is an alternative to Original Medicare offered by private insurance companies approved by Medicare. Instead of getting your benefits directly from the government, you get them through a private plan.

These plans must cover everything Original Medicare covers (Parts A and B), and most also include Part D drug coverage, dental, vision, and hearing, extras that Original Medicare doesn't cover.

> Many Medicare Advantage plans have $0 premiums, but that doesn't mean they're free. You still pay your Part B premium, and you'll have copays and cost-sharing when you use care.

How Medicare Advantage Plans Work

When you enroll in a Medicare Advantage plan, Medicare pays the private insurer a fixed amount each month to provide your coverage. The insurer then manages your benefits and sets the rules for how you access care.

- **Network restrictions:** Most plans require you to use in-network providers (HMO) or pay more for out-of-network care (PPO).
- **Referrals:** HMO plans often require a referral from your primary care doctor to see a specialist.
- **Prior authorization:** Plans can require pre-approval for certain procedures, medications, or specialist visits.
- **Out-of-pocket maximum:** All MA plans must cap your annual out-of-pocket costs (in 2026, the cap is $9,250 for in-network).

Pros of Medicare Advantage

- Often lower monthly premiums (sometimes $0)

- Includes extras like dental, vision, hearing, and fitness benefits
- Built-in out-of-pocket maximum protects you from catastrophic costs
- Drug coverage (Part D) usually included
- Simple, all-in-one plan

Cons of Medicare Advantage

- Network restrictions. Your doctors may not be in-network
- Prior authorization can delay care
- Plans change every year (benefits, networks, costs)
- If you travel frequently or live in multiple states, coverage can be limited
- Harder to switch to a Medigap plan later if you develop health problems

The biggest mistake people make: enrolling in Medicare Advantage at 65 and then trying to switch to a Medigap supplement at 70 after a health diagnosis, and getting denied or paying much higher rates due to medical underwriting.

FROM MATT'S DESK

Linda K. enrolled in a $0-premium Advantage plan at 65. She was healthy, and it made sense at the time. At 69 she was diagnosed with a heart condition, and when she tried to switch to a Medigap plan for more freedom with specialists, she was declined by two carriers and quoted nearly double by a third because of medical underwriting. She's still on an Advantage plan today, and manages fine, but the choice she made at 65 turned out to be closer to permanent than anyone told her.

Client stories reflect real situations from Matt's practice. Names and identifying details are changed for privacy.

Before you enroll in any Advantage plan: have someone verify your doctors are in-network and your drugs are on the formulary. Matt does this check for free. Most people are shocked by what they find.

> **Weighing these tradeoffs for your own situation?** This is exactly the conversation Matt has with clients every day: your doctors, your medications, your budget, your risk tolerance. Fifteen minutes and you'll know which side of this line you're on.

Is Medicare Advantage Right for You?

Medicare Advantage can be a great fit if you're relatively healthy, have a preferred network of doctors in-plan, want extra benefits, and want to keep costs simple. It's not ideal if you travel frequently, have complex medical needs, or value the freedom to see any doctor without referrals.

Thinking About an Advantage Plan?

Before you enroll, have Matt verify your doctors are in-network and your medications are on the formulary. Ten minutes now beats a year locked into the wrong plan.

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MODULE 3

Medicare Supplement (Medigap)

How Medigap fills the gaps in Original Medicare, and why the timing of this decision matters more than the plan letter itself.

What Is Medicare Supplement (Medigap)?

A Medicare Supplement plan, often called Medigap, is private insurance that works alongside Original Medicare (Parts A and B) to help cover the "gaps" in coverage, such as copays, coinsurance, and deductibles.

Unlike Medicare Advantage, Medigap doesn't replace Original Medicare. It supplements it. You keep your Original Medicare card and use it first; your Medigap plan pays second.

> With a strong Medigap plan, you can see virtually any doctor or specialist in the country who accepts Medicare: no referrals, no networks, no prior authorization.

The Standardized Plan Letters

Medigap plans are standardized by the federal government and sold under letter names (A, B, C, D, F, G, K, L, M, N). Every insurer must offer the same benefits for the same plan letter. The only difference is price and customer service.

- **Plan G:** The most popular plan for new enrollees. Covers almost everything except the Part B deductible ($283 in 2026). Great for people who want comprehensive coverage and budget predictability.
- **Plan N:** Similar to Plan G but with small copays ($20 for doctor visits, $50 for ER). Lower premiums than Plan G. Good for healthy people who don't visit doctors frequently.
- **Plan F:** The most comprehensive, covers 100% of approved Medicare costs. Only available to those who became eligible for Medicare before January 1, 2020.
- **Plan K & L:** Lower premiums with cost-sharing requirements. Good for healthy enrollees willing to take on more risk.

Medigap vs. Medicare Advantage

This is the core decision most people face. Here's a simple way to think about it:

- **Medigap + Original Medicare:** Higher monthly premium, but near-zero out-of-pocket costs when you need care. Maximum freedom to use any Medicare provider nationwide.
- **Medicare Advantage:** Often lower monthly premium, but potential for significant cost-sharing when you need care. Network restrictions apply.

Timing matters. You have a guaranteed issue right to enroll in any Medigap plan without medical underwriting during your 6-month Medigap Open Enrollment Period (starts when you're 65 and enrolled in Part B). After that, insurers can deny you or charge more based on health.

FROM MATT'S DESK

Carol M. already had type 2 diabetes when she turned 65. During her Medigap Open Enrollment window, that didn't matter. She enrolled in Plan G with zero health questions, same rate as anyone else. Compare that to a gentleman who called me at 68 wanting the same plan: same condition, but past his window, he had to go through underwriting and was declined. Same person on paper. The only difference was timing.

Client stories reflect real situations from Matt's practice. Names and identifying details are changed for privacy.

Already past your open enrollment window? Don't assume you're stuck. Some states have birthday rules and exceptions, and certain situations restore your guaranteed-issue rights. Matt can check what applies to you in one call.

What Medigap Doesn't Cover

- Prescription drugs (you need a separate Part D plan)
- Dental, vision, and hearing
- Long-term care
- Care outside the U.S. (some plans offer limited foreign travel coverage)

Find Out What Your Window Looks Like

Your 6-month Medigap open enrollment only comes once. Matt will tell you exactly when yours opens and closes, and what Plan G vs. Plan N actually costs in your zip code.

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MODULE 4

Part D: Prescription Drug Coverage

How Part D works and how to pick a drug plan by what it actually costs you at the pharmacy, not by the premium on the list.

What Is Medicare Part D?

Medicare Part D is the prescription drug benefit. It's offered through private insurance companies approved by Medicare and can be added to Original Medicare (as a standalone Prescription Drug Plan) or is often built into Medicare Advantage plans.

Part D is optional, but if you don't enroll when you're first eligible and go without creditable drug coverage, you'll face a late enrollment penalty that lasts as long as you have Medicare.

> Even if you take no medications right now, enrolling in a low-cost Part D plan when you first become eligible protects you from the late enrollment penalty later.

How Part D Works: The Phases

Part D has a coverage structure with different phases of cost-sharing:

- **Deductible Phase:** You pay 100% of drug costs until you meet your plan's deductible (up to $615 in 2026). Some plans waive the deductible for certain drug tiers.
- **Initial Coverage Phase:** You pay your plan's copay or coinsurance after the deductible. The plan pays the rest.
- **Catastrophic Coverage:** In 2026, after you spend $2,100 out-of-pocket on covered drugs, you pay nothing for the rest of the year. This is a major improvement from prior years.

Formularies: The Drug List

Every Part D plan has a formulary. A list of covered drugs organized into tiers. Lower tiers mean lower copays (generics), higher tiers mean higher costs (brand-name and specialty drugs).

Before enrolling in any Part D plan, always check that your specific medications are on the formulary at an acceptable cost tier. This is the single most important factor in choosing a drug plan.

FROM MATT'S DESK

Jim T. picked his Part D plan the way most people do: lowest premium on the list. What he didn't check: his brand-name blood thinner wasn't on that plan's formulary. He spent months paying over $300 out of pocket before we talked. At the next Annual Enrollment Period, we moved him to a plan with a slightly higher premium where the same drug was a tier-3 copay. His total yearly drug cost dropped by thousands.

Client stories reflect real situations from Matt's practice. Names and identifying details are changed for privacy.

Don't want to do this yourself? Matt runs your exact drug list through every plan in your zip code and hands you the answer. It's free, and it's the single fastest way to stop overpaying for prescriptions.

The Late Enrollment Penalty

If you don't enroll in Part D when first eligible and later decide you want coverage, Medicare charges a late enrollment penalty of 1% of the national base premium ($38.99 in 2026) for every month you went without creditable coverage. Real math: skip coverage for 3 years, and that's roughly $14 added to your premium every single month, permanently. You pay it for life.

If you have drug coverage through an employer, union, or other source, make sure it qualifies as "creditable coverage" (as good as Medicare's). Get that in writing every year.

Choosing the Right Part D Plan

Use Medicare's Plan Finder tool at **medicare.gov** to compare plans based on your specific medications. Don't just pick the lowest premium. A plan with a $5 higher premium might save you $100/month on your specific drugs.

Never Overpay for Your Medications

Matt runs your exact drug list through every plan in your zip code and hands you the answer. Free, and the single fastest way to find savings on Medicare.

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MODULE 5

Enrollment Periods

Every enrollment window that applies to you, and which mistakes carry penalties that never go away. This is the module where timing turns into money.

Why Enrollment Periods Matter

> **The one question this module can't answer:** which of these windows is open for YOU right now. That depends on your birthday, your work situation, and your state. Matt maps it in one short call, before a window closes without you knowing it existed.

Medicare enrollment isn't as simple as signing up whenever you want. There are specific windows when you can enroll, make changes, or switch plans, and missing the wrong window can mean gaps in coverage, permanent penalties, or being stuck with a plan you don't want for a full year.

Initial Enrollment Period (IEP)

This is your first opportunity to enroll in Medicare. It's a 7-month window:

- 3 months before your 65th birthday month
- Your birthday month
- 3 months after your birthday month

Enroll in the 3 months before your birthday month and coverage starts the first of your birthday month. Enroll during your birthday month or the 3 months after, and coverage starts the first of the month after you sign up.

If you're still working at 65 and have employer coverage through a current employer with 20 or more employees, you may be able to delay both Part A and Part B without penalty. Ask your HR department and confirm in writing.

HSA Users, Important: If you are still working at 65 and contributing to a Health Savings Account (HSA), you should delay *both* Part A and Part B. The moment you enroll in any part of Medicare, including premium-free Part A, you are no longer allowed to contribute to an HSA. Most people know to delay Part B with employer coverage, but don't realize that enrolling in Part A also stops HSA contributions. If you want to continue contributing to your HSA, delay both parts until you stop working. You will not be penalized for this as long as you have creditable employer coverage.

> **Confused about YOUR dates?** This is the module where mistakes get expensive. One call with your birthday and work situation, and Matt will lay out every window that applies to you, in writing.

Special Enrollment Period (SEP)

If you delayed Medicare because you had coverage through a current employer (yours or a spouse's), you qualify for a Special Enrollment Period when that coverage ends. You have 8 months to enroll in Part A and/or Part B without penalty.

Important: COBRA and retiree health coverage do NOT count as current employer coverage for SEP purposes.

FROM MATT'S DESK

Robert H. retired at 66 and stayed on COBRA because it felt like "keeping his coverage." Nobody told him COBRA doesn't count as employer coverage for Medicare's Special Enrollment Period. By the time COBRA ran out, his 8-month window had closed. He had to wait for the General Enrollment Period, went months without Part B, and now pays a late enrollment penalty on top of his premium. Every month. For life. One 10-minute conversation before he retired would have prevented all of it.

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General Enrollment Period (GEP)

If you missed your IEP and don't qualify for an SEP, you can enroll during the General Enrollment Period: **January 1 – March 31 each year**. Your coverage starts the first of the month after you sign up. Late enrollment penalties will apply.

Annual Election Period (AEP): Open Enrollment

Every year from **October 15 – December 7**, anyone with Medicare can:

- Switch from Original Medicare to Medicare Advantage (or vice versa)
- Switch from one Medicare Advantage plan to another
- Join, switch, or drop a Part D drug plan

Changes made during AEP take effect January 1 of the following year.

Medicare Advantage Open Enrollment Period (OEP)

From **January 1 – March 31** each year, if you're enrolled in a Medicare Advantage plan you can:

- Switch to a different Medicare Advantage plan
- Switch back to Original Medicare (and enroll in a standalone Part D plan)

Medigap Open Enrollment Period

This is the most important window for Medigap: a **6-month period starting when you're 65 and enrolled in Part B**. During this window you have a guaranteed right to buy any Medigap plan sold in your state, insurers cannot deny you or charge more based on health conditions.

> After your Medigap Open Enrollment Period ends, insurers can use medical underwriting. If you develop a health condition, you may be denied or charged significantly more. This window only comes once, use it wisely.

Special Enrollment Periods for Medicare Advantage & Part D

Certain life events (moving out of your plan's service area, losing employer coverage, qualifying for Medicaid, or your plan leaving Medicare) trigger Special Enrollment Periods that allow you to make changes outside the normal windows.

Get Your Exact Dates

Tell Matt your birthday and your work situation. He'll map every window that applies to you: your IEP, your Medigap open enrollment, and any special periods. Two minutes of info, zero guesswork.

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MODULE 6

What Medicare Doesn't Cover and How to Plan for the Gaps

The gaps that catch people off guard, some of them five and six figures. Then a clear next step so none of them catch you.

The Coverage Gaps Most People Don't Know About

Most people assume Medicare covers everything health-related after 65. It doesn't. These are the biggest gaps that catch people off guard, and can cost tens of thousands of dollars if you're not prepared.

Dental

Original Medicare does NOT cover routine cleanings, fillings, root canals, crowns, dentures, or most extractions. Some Medicare Advantage plans include basic dental, but benefits are typically capped at $1,500–$2,000/year.

Vision

No coverage for routine eye exams, glasses, or contact lenses. Medicare does cover medically necessary treatment for eye diseases like glaucoma and cataracts, but not your regular vision care.

Hearing

No coverage for hearing exams for fitting hearing aids or the hearing aids themselves. Hearing aids can cost $2,000–$4,000+ per ear, and Medicare pays nothing toward them under Original Medicare.

Long-Term Care

This is the biggest gap. Medicare does NOT cover custodial care, help with bathing, dressing, eating, or getting around in a nursing home or at home. Average nursing home cost: $8,000–$10,000/month.

Overseas Medical Care

Medicare generally doesn't cover medical care outside the U.S. There are only three very limited exceptions. If you travel internationally, you need separate travel health insurance.

Most Outpatient Prescriptions

Original Medicare Parts A and B do NOT cover most self-administered prescription drugs. You need a separate Part D plan or a Medicare Advantage plan that includes drug coverage.

The Nursing Home Trap
Medicare DOES cover short-term skilled nursing facility care, but only after a qualifying 3-day inpatient hospital stay and only for medically necessary skilled care. Days 1–20 are covered. Days 21–100 cost $217/day. After day 100, Medicare pays nothing. Long-term custodial care is never covered.

What's Covered vs. What's Not: A Quick Reference

- Hospital stays (inpatient, Part A)
- Doctor visits and outpatient care (Part B)
- Preventive screenings and annual wellness visits
- Short-term skilled nursing facility care (with qualifying hospital stay)
- Hospice care
- Home health care (medically necessary, skilled care)

- Durable medical equipment (wheelchairs, walkers, etc.)
- Mental health services (outpatient therapy)
- Routine dental, vision, and hearing
- Long-term custodial care (nursing homes, assisted living)
- Most prescription drugs without Part D
- Medical care outside the United States
- Cosmetic surgery
- Most chiropractic care (only spinal subluxation)

How to Fill the Gaps: Your Coverage Toolkit

Medicare, and even Medicare plus a Supplement, was never designed to cover everything. Each gap below has a purpose-built, usually inexpensive product that closes it. Matt handles all of these on the same free call, so you can see which ones actually apply to you and skip the ones that don't.

FOR THE SUPPLEMENT PATH

Dental, Vision & Hearing (DVH)

Original Medicare and Medigap cover none of the big three: dentures, implants, glasses, hearing aids. A standalone DVH plan fills all three at once, typically for a modest monthly premium, and unlike many Advantage extras, benefits are defined and yours to use anywhere.

FOR THE ADVANTAGE PATH

Hospital Indemnity

Advantage plans commonly charge daily copays for hospital stays, often hundreds of dollars per day for the first week. A hospital indemnity plan pays YOU a fixed cash amount per day in the hospital, turning your plan's biggest exposure into a covered, predictable event.

FOR EVERYONE

Cancer, Heart Attack & Stroke

A serious diagnosis brings costs no medical plan touches: travel to treatment centers, lodging, lost income, help at home. Critical illness plans pay a lump sum in cash, directly to you, at diagnosis. You decide how to use it.

FOR EVERYONE

Life Insurance

Final expenses, income for a surviving spouse, or simply making sure the funeral is never your family's bill. Options exist at every age and budget, including plans with no medical exam, and locking in coverage is easier and cheaper the earlier you do it.

FOR EVERYONE

Custodial Care: Short & Long-Term Care

The single biggest gap in all of Medicare. Help with bathing, dressing, eating, memory care: Medicare calls it custodial, not medical, and pays nothing, whether it's needed for three months of recovery or three years in a facility. Short-term care plans cover recovery-length needs affordably; long-term care insurance, hybrid life/LTC policies, and asset-based strategies handle the rest. This is the conversation to have while you're healthy enough to qualify.

Which of these do you actually need?
Probably not all of them. The right mix depends on your Medicare path, your health, your family history, and your budget. That's exactly what the free review sorts out: which gaps are real for you, which products close them, and which ones you can safely skip.

FROM MATT'S DESK

When **Diane S.**'s mother needed memory care, the family assumed Medicare would handle it. She'd paid in her whole life, after all. The facility quoted $9,500 a month, and Medicare covered none of it, because custodial care isn't medical care in Medicare's eyes. The family spent down savings for two years before qualifying for other help. Diane became a client afterward specifically to make sure her own kids never face that surprise.

Client stories reflect real situations from Matt's practice. Names and identifying details are changed for privacy.

What Happens on Your Free Review Call?

- Matt reviews your current plan (or helps you pick your first one)
- You confirm your doctors and specialists are covered
- Your medications are checked against plan formularies
- Costs are compared across available plans in your area
- You leave with a clear, personalized recommendation
- You see which coverage-gap products (DVH, hospital indemnity, cancer/heart/stroke, life, care plans) apply to you, and which don't
- Ongoing support every year at Annual Enrollment Period

Matt is a licensed independent Medicare advisor. His services are 100% free to you: agents are compensated by insurance carriers, not by clients.

You've Completed the Guide!

You now know more about Medicare than most people approaching 65. But knowledge only matters when it's applied to YOUR situation. Your doctors, your medications, your budget, your state.

The free review takes 15–30 minutes and could save you thousands. No pressure, no sales pitch, and no cost, ever: Matt is paid by insurance carriers, not by you.

Worst case? You spend 15 minutes confirming you're already set up right, and you get that peace of mind in writing. Best case, Matt finds money you're leaving on the table every single month.

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